

For Washington State Nursing Home staff

From Residential Care Services, Aging and Disability Services
Department of Social & Health Services

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our mascot
Cousin IT

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"This is I.T." Newsletter

Info and Tips from the MDS-WA Office—**Clinical stuff,**
Computer stuff, Reports 'n stuff, and other STUFF!

By Marge Ray and Shirley Stirling, State of WA, DSHS

Hydration/Dehydration Section J & K

As April showers bring May flowers, we need water for the distribution of nutrients to cells, the elimination of waste, regulation of body temperature and several other complex processes. When water or fluid loss (output) far exceeds intake, dehydration occurs. Normal loss of fluid through the skin (perspiration) and lungs (exhaling) is about 500 ml per day (a little over 2 glasses). So... any decrease in fluid intake for any reason can result in dehydration.

It is often hard to recognize when a frail chronically ill elder suffers dehydration, or the reverse - fluid overload.

Careful observation and interview of the resident and staff, plus accurate record keeping, provide important information to identify at-risk individuals. Section J and K of the MDS cover the details of fluid maintenance and dehydration.

Section J records problems or symptoms that could affect the resident's health or functional status. It also identifies risk factors for illness, accidents and functional decline.

While Section K is focused on recognizing factors that impact nutritional status, there are also many conditions that can affect the resident's ability to consume fluids and maintain adequate hydration. Let's take a look at some of

the MDS items that cover potential hydration concerns.

J1a asks if the resident has gained or lost 3 or more pounds over the 7-day look-back period. Most residents don't need weekly or more frequent weight measures, thus you will not be able to determine if the weight changes have occurred and the item can be left blank. For residents who need to be weighed at least weekly you must weigh the resident in the same way each time: use the same chair and scale with the resident wearing the same amount/type of clothing at about the same time.

J1b captures whether the resident has shortness of breath when lying flat. This often occurs with fluid overload. **J1i**, asks if the resident has trouble breathing with other events (at rest, with activity, in response to illness or anxiety). You can code one or both items.

J1d asks whether the resident consumed all or most of the liquids provided over the last 3 days. It is important to understand that this is only coded if the resident first receives the proper amount of fluids and then does not consume all or most of those fluids. Also, the look-back for this item is only 3 days (ARD + 2 days).

Liquids can include water, juice, coffee, tea, Jell-O, and soup. You must use a method of gathering intake info for this 3 day period to code a correct response.

J1c dehydrated: output exceeds intake. This item is checked if two or more of the following are present:

- The resident takes in less than 1500 ml of fluids daily (water or beverages and food high fluid content foods such as gelatin or soup).

- The resident has one or more signs of dehydration such as dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).

- The resident has fluid loss that exceeds the fluid taken in. This could be from vomiting, fever or diarrhea that exceeds fluid replacement.

K1b swallowing problem: Dysphagia, an oral problem includes frequent choking and coughing when eating or drinking- among other symptoms. Check this item even if successful interventions are in place.



Shirley Marge

Our goal...

Our goal is to help you accurately assess, code, and transmit the MDS.

Accurate assessment forms a solid foundation for individualized care to help residents achieve their highest level of well-being.

K1c mouth pain asks if the resident has pain or discomfort of any part of the mouth regardless of cause. Symptoms may include refusing fluids of certain temperatures (hot or cold).

K5a asks if the resident had IV fluids or hyperalimentation continuously or intermittently for nutrition or hydration during the 7-day look back period. There must be supporting documentation to show that the fluids were given for nutrition or hydration, otherwise K5a cannot be coded.

Hydration Habits

There are many factors that contribute to a resident's ability to maintain adequate fluid intake. Understanding a residents hydration habits is important as these may represent a lifetime pattern or they could reflect an attempt to adapt to their current environment or health status.

- Does the individual like tap water, ice water, warm water?
- Do they use a coffee cup or mug for their beverages or a glass with a straw?
- How accessible are drinking fountains or other water sources?
- What are the fluids of choice and are they provided?
- Is the resident purposefully limiting fluid intake to avoid having to go the bathroom frequently?
- Does the resident understand that water from the tap in the bathroom is the same as the water from the kitchen tap?



Does the resident have dementia, aphasia or other conditions that make communicating the need for fluids difficult? Residents in nursing homes have many challenging conditions that could affect their ability to consume fluids and maintain adequate hydration. Early problem recognition will help ensure appropriate and timely intervention.

Dial-Up Modems are out. Broadband is now required.

On February 1st, 2009 CMS began the process of discontinuing dial up accounts nationwide.

If you are still using a dial-up modem, your access may be discontinued at any time without further notice as this project is over a year old. Please take action now to convert to a broadband connection. Your delay increases government costs.

If you are not using a broadband connection for MDCN, an update has been posted at <https://www.gtso.com>. Click on the MDCN Information link in the blue outlined box on the right hand

side of the page. The client version 7.2.1 and set up instructions are posted. Contact your state coordinator for information about your new password under broadband.

If you are using a network, a revised network document is available for download. Please forward it to your network administrators. They will need the port information to ensure a successful connection.

The MDCN Help Desk is available to support your efforts at 800-905-2069; choose option 2 for technical support.

MDS 2.0 Training to Resume

With the postponement of MDS 3.0, Residential Care Services will be providing additional MDS 2.0 training sessions starting in the summer of 2009.

These classes are basic in nature and are intended for nursing home staff new to the MDS or for staff who feel the need for a refresher. Each course is 2-days in length and covers assessment types, scheduling requirements, item-by-item review of the majority of MDS sections, some information on RAPS, Significant Change in Status, completion of tracking forms and error correction.

The first series is scheduled for June and July; the second for October and November; and the third for March and April 2010.

Specific information related to dates, location, and pre-registration will be sent to each facility via a Dear Administrator letter as well as being posted on our website:

www.adsa.dshs.wa.gov/professional/nh.htm
(scroll down to MDS 2009 Training).

Q2IT Tips from the Treasure Trove



Questions to I.T. (Q2 IT) on Section J1c— Dehydration

Question: If the physician documents a diagnosis of dehydration in the clinical record, can I code J1c based on that diagnosis?

Answer: No, you cannot. J1c has specific criteria that must be met in order to code it and having a physician documented diagnosis is not one of the criteria. (See RAI manual chapter 3 page 138). The diagnosis may be recorded in Section I item 3 if it meets the criteria for coding.

Question: Do I have to put all the residents on Intake and Output?

Answer: There is no requirement to do intake and output monitoring to code J1c. However, the facility must have some method of determining if the resident actually consumed the recommended 1500 ml of fluid per day as this is one of the 3 criteria for coding this item.

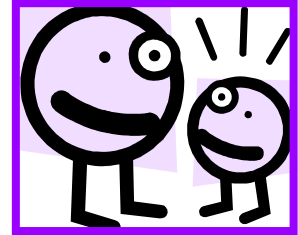
Question: Most of our residents have dementia and are confused, wouldn't that automatically mean that they meet one of the criteria to code J1c?

Answer: Not necessarily. Just because residents have dementia, does not mean that there are dehydrated. The RAI manual speaks to new onset of confusion or an increased level of confusion as being a symptom not simply being confused.

Connecting the MDS Dots

Several RAPS are triggered from these MDS items:

- Dehydration/Fluid Maintenance is triggered when J1a, c, d or K5a is checked and when the ICD-9 codes of 276.5, 276.51 or 276.52 is entered in I3
- Psychotropic Drug Use is triggered when K1b is checked
- Dental Care is triggered when K1c is checked
- Nutritional Status is triggered when K5a is checked



Quality Measure/Indicators:

- Residents will flag Quality Measure/Indicator 7.3 Prevalence of dehydration if J1c is checked or I3 is coded with 276.5 on the target assessment.

Survey:

- J1c is a sentinel event that requires investigation during the annual inspection.
- F327 Hydration: The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

Payment:

- J1c and K5a are RUG items used in the case mix payment classification system.

QM/QI Report 7.3-Prevalence of Dehydration

Quarter 1 through Quarter 3 of 2008:

Nation	0.2%
Region	0.6%
Washington	1.0%



The Washington State percentages for dehydration listed in QM/QI reports (see quarters compiled above) are based on coded MDS data. This data makes it appear as though Washington State is a great deal higher in this area than the national average. **Action Requested:** Please pull your facility level CASPER QI/QM reports and see how your NH compares. Are the MDS items affecting the prevalence of dehydration coded correctly in your resident assessments?

Keeping on Target—Odds and Ends

The following points are odds and ends of important details to help you ensure that your finalized MDS is right on target:

Face Sheet Sections AB, AC, AD

Normally, the face sheet is only completed when the resident first enters the nursing home or returns after being discharged return not anticipated. As a result, this section or a copy of this section needs to be kept on the resident's active chart. (MDS manual chapter 1, page 27).

The date of entry, AB1 does not change every time the resident goes to and returns from an acute care hospitalization. It will only change when a resident is discharged return not anticipated (AA8=06) and later returns to the nursing home as a new admission. (MDS manual chapter 3 page 12-13).

Discharge Tracking If the resident is discharged to the hospital before the initial OBRA MDS with RAPS is done the only code you can use on the discharge tracker is the code of "08" Discharged prior to completion of initial assessment. The 5-day Medicare assessment is not the same as the initial OBRA assessment. (MDS manual chapter 2, pages 23-25).

Error Correction If you have made an error in selecting the reason for the assessment or the reason for completing the tracking form and you have submitted the document to the state data base, the only way it can be corrected is through the electronic correction process choosing "Inactivation". You cannot chose "Modification" as the system will not allow this type of correction. (MDS manual, chapter 5).

IV Medication –P1a c The use of dextrose 50% solution given IV for diabetic



hypoglycemic episodes cannot be coded as an IV medication on the MDS per CMS representatives. While this prepara-

tion is an effective treatment for hypoglycemia, it is not classified as a medication, but as a carbohydrate, caloric agent.

P1a Special Care / Treatments It is necessary to see documentation validating that the special treatments occurred. A physician's order plus documentation that the order has been carried out, or a documented phone interview to the agency/facility that administered the treatment are examples of proper validation. The NH should have this evidence of actual receipt of the treatment or procedure at the time the MDS is coded. A physician order for treatment alone does not provide proof of administration.

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For WA State Nursing Home Staff

A Newsletter from
Residential Care
Services Of Aging &
Disability Services
Administration

State of WA NH web sites

MDS Clinical web page

<http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/>

MDS Automation web page

<http://www.adsa.dshs.wa.gov/Professional/MDS/Automation/>

NH Rates web page

<http://www.adsa.dshs.wa.gov/professional/rates/>

Casemix web page

<http://www.adsa.dshs.wa.gov/professional/CaseMix/>

“Dear Administrator “ web page

<http://www.ADSA.dshs.wa.gov/professional/letters/nh/2008/>

ADSA on the Web!

<http://www.adsa.dshs.wa.gov/Professional/>

Washington State RUG Reports are now offered exclusively on the MDS Transmission site. Notices are sent out on the MDS-WA Listserv as reports are posted. Other notices are sent usually up to about four times month. To join, send an email to LISTSERV@LISTSERV.WA.GOV and put this text in the subject line **SUBSCRIBE MDS-WA**

MDS 3.0 Update

It was announced during the March 5, 2009 Open Door Forum that MDS 3.0 has been postponed until October 1, 2010.

According to Tom Dudley & Sheila Lambowitz, CMS officials, they are working very hard and very carefully to make sure that all the needs from all stakeholders along with all programs and systems that rely on the MDS, can be updated to work efficiently with MDS 3.0.



to

In order to accomplish this, CMS is stepping back and taking more time. A revised time table was posted April 16, 2009 on the MDS 3.0 website:

www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Further information will be made available at subsequent Open Door Forums as well.

Computer Corner

by Shirley Stirling



Sometimes it rains **cats and dogs** and there is not much one can do about it other than find an umbrella!



That's how I feel about all the changes we are having with MDS related technology!

In the last few months:

- We have switched to Broadband technology for MDS input.
- We have gone to all on-line State Medicaid RUG reports.
- We have the new 5-Star Reporting system with Preview reports in CASPER.
- We have enabled Section T in Washington State for OBRA to allow a Medicaid RUG calculation.
- We are getting a new MDS server in Washington State on April 30 & May 1.
- Sometime soon we will transition to a new MDS personal Login ID system.

Nothing is ever as simple as it would appear at first glance. I am glad that the MDS 3.0 has been delayed to allow us time to make the above changes, to smooth out bumpy issues, and to solve conundrums before we have the challenges of a new MDS tool.

And I am especially glad that I have such a great group of nursing home staff and vendors to work with on these and other issues.

Gratitude Most of all, I want to take this opportunity to THANK YOU for your patience, good humor, and persistence in making these transitions. My exchanges with you, the nursing home staff, MDS vendors, and corporate representatives serving Washington State are consistently a pleasure and I find that, in our positive exchanges, we are able to solve problems that might otherwise seem insurmountable.



Please read the MDS-WA Listserv (see above) for new developments, tips, tricks, and notices on MDS and give the link to anyone who would like to receive these emails directly.

Also, feel free to get a hold of me on any technical issues via the contact info at the top of this page. There you will also find contact information for Marge Ray, RAI coordinator and clinical specialist. We are both happy to work with you at any time to find an umbrella!

Shirley